Maryland Health Quality and Cost Council
Monday, March 14, 2011
9:30 a.m. – 12:00 p.m.
UMBC Technology Center

MEETING NOTES

Members present: Lt. Governor Brown (Chair), Sec. Joshua Sharfstein (Vice Chair), Debbie Chang, James Chesley, Richard "Chip" Davis, Barbara Epke, Roger Merrill, Marcos Pesquera, Frances Phillips, E. Albert Reece, Christine Wray, Kathleen White and via telephone, Jill Berger.

Members absent: Peggy O'Kane and Reed Tuckson

Staff: Nicole Stallings, Karen Rezabek, and Grace Zaczek

Meeting Materials

All meeting materials are available at Council's website:
http://dhmh.maryland.gov/mhqcc/meetings.html

Welcome and Approval of Minutes

The meeting was called to order at 9:15 with opening remarks from Lt. Governor Brown. The Lt. Governor welcomed Secretary Sharfstein to Maryland and to the Council. Secretary Sharstein commented on the exciting time to be in state government and that he has already learned of the value of the work of the Council by participating in a hand hygiene learning session, personally calling several participants in Healthiest Maryland Businesses, and engaging CMS on the patient centered medical home pilot. Secretary Sharfstein then introduced two new members of the Council: Christine Wray, President of St. Mary's Hospital and Marcos Pesquera, Executive Director, Center for Health Disparities at Adventist HealthCare. The December 10, 2010 meeting minutes were approved.

UPDATE PRESENTATIONS

Federal Health Care Reform and Maryland Implementation – Lt. Governor Brown and Secretary Sharfstein

The Lt. Governor and Secretary Sharfstein provided an update of implementation activity since the December meeting of the Quality and Cost Council. The Health Care Reform Coordinating Council (HCRCC) submitted a report with recommendations to the Governor and implementation is now taking place during the State's 90-Day Legislative Session. The Administration introduced a legislative package related to reform, specifically the development of the governance structure of the Exchange, health insurance market reforms and a third bill which would extend the work of this Council. Secretary Sharfstein commented that it is clear that

the goals of the HCRCC closely align with those of the Quality and Cost Council, which can be the vehicle by which to deal specific of quality improvement and cost containment initiatives. The Lt. Governor noted that an Executive Order would be issued in lieu of legislation to expand the work of the Quality and Cost Council. Discussion then ensured regarding the goals of the Exchange and the specific provisions of the legislation. The Lt. Governor commented on the need to intensify the Council's focus on health disparities and suggested a more focused approach through a workgroup may be appropriate. The Lt. Governor then announced suggested that the creation of the Governor's Office of Health Reform to coordinate the work across state agencies and to staff the HCRCC would be forthcoming. The Chairs agreed that the work of this Council will continue, and is more important than ever as we work to introduce quality improvement and cost containment initiatives in the public and private sector.

Maryland Multipayer PCMH Program - Kathleen White, Johns Hopkins University School of Nursing and Ben Steffen, Maryland Health Care Commission

Dr. White began the presentation (available on the MHQCC website) with an application update, commenting that participating practices in the Maryland Multi-Payer PCMH Program(MMPP) represent diverse service types and locations, which is ideal to serve a broad base of Maryland patients. Mr. Steffen provided detail regarding the 61 practices that have been invited to participate in the program. Practices include physicians and nurse practitioner-led pediatric, family practice, internal medicine and geriatric practices. These practice sites include 300 providers and serve more than 300,000 patients. Participation agreements are finalized and an evaluation RFP has been released, with responses due later this month. Mr. Steffen then commented that the University of Maryland School of Maryland and Johns Hopkins Community Physicians will assist with practice transformation. Unanticipated challenges include an overlap between the MMPP and CareFirst programs, the time commitment required to outreach to self funded employers and the budget constraints that have limited the degree to which Medicaid can participate. Mr. Steffen agreed to provide the Council with an update at the June meeting.

Telemedicine Task Force - Robert Bass, Maryland Institute for Emergency Medical Services Systems (MIEMSS)

Dr. Bass provided the Council with a brief update on the Telemedicine Initiative and related legislation under consideration by the General Assembly. While the Taskforce is not meeting during the legislative session, members have provided comment on several pieces of legislation relating to telemedicine as well as participated in legislative briefings. Legislation has been introduced that would establish a task force to look at the use of telemedicine in medically underserved areas. State agencies have committed to incorporate the provisions of that legislation into the activity of the three advisory committees of the Taskforce and the subsequent report to the Council and Governor. Dr. Bass reminded the Council that three advisory groups will be developed to replace the Telemedicine Taskforce:

1) **Clinical Advisory Group**
2) **Technical Solutions and Standards Advisory Group**
3) **Financial and Business Model Advisory Group**

Dr. Bass then discussed composition of the advisory committees, assuring Council members that they would be broadly inclusive. It was also agreed that there was much to learn from other states, such as Georgia and Alaska. It is anticipated that the Clinical Advisory Group would make their recommendations prior to the bulk of the work by the Technical Solutions/Standards Advisory Group and Financial Group. The work will take place primarily during spring (upon conclusion of the Legislative Session) and summer of 2011, with a quarterly update to the Quality and Cost Council and a Final Report submitted to the Governor by January of 2012.

Healthiest Maryland Businesses - Frances Phillips, Deputy Secretary, Public Health Services and Judith Shinogle, Senior Research Scientist, MIPAR

Deputy Secretary Phillips began the presentation (available on the MHQCC website) with preliminary evaluation results of the Healthiest Maryland Businesses (HMB) initiative. To date, HMB has 112 participating businesses, which cover an estimated 175,000 employees. She also noted that the Injured Workers Insurance Fund (IWIF) is a new partner and that the Secretary and Lt. Governor would be presenting on HMB at their June 3 Wellness Symposium. Dr. Shinogle provided the Council with an overview of the evaluation plan, which is a mixed method approach including qualitative phone interviews, analysis of intake data, and web surveys. Challenges include the different stages of implementation of participating businesses. Intake data suggests that more information is needed on programs and implementation and that health risk assessments, incentive programs, education and evaluation are necessary resources. Next steps include enhancements to the evaluation including web surveys comparing participants and matched companies and to conduct key company analysis to examine the overall effect of worksite wellness and HMB's impact. Ms. Phillips then informed the Council that HMB will continue to focus on recruitment and will look to hold a Southern Maryland launch as well as look for additional opportunities for recruitment events. Technical assistance will also be enhanced to ensure a warm hand off between DHMH and supporting organizations and to increase the number of supporting organizations able to provide technical assistance. Deputy Secretary Phillips will provide an update of HMB enrollment and evaluation at the June Council meeting.

ACTION ITEMS

Evidence-based Medicine Workgroup: Update and Future Initiatives - Richard "Chip" Davis, Johns Hopkins Medicine

Dr. Davis' presentation (available on the MHQCC website) began with an update of the Maryland Hospital Hand Hygiene Collaborative. Dr. Davis reminded the Council that 31 acute care hospitals are participating in the Collaborative. Among the 31 hospitals, the total number of participating units as of September 2010 (including Med-Surgical, Pediatrics, and ICU) is 373. Of these, 353 are acute care units ad 20 are specialty units. This represents 6,842 beds, or 77 percent of all Maryland medical/surgical beds. The Collaborative average for hand hygiene compliance is 75%. Next steps include strengthening the capability of hospital programs through monthly hand hygiene team calls, technical assistance calls, targeted site visits, and CEO report cards. The Collaborative will continue past the original June 2011 termination date. The Workgroup will consider looking for associations between compliance data and healthcare

associated infections as well as ways to expand the program to additional acute care hospitals or non acute hospital settings. Secretary Sharfstein commented that he would write to each of the non-participating hospitals encouraging their participation.

Barbara Epke then provided the Council with an update of the *On the CUSP: Stop BSI* initiative. The CUSP program has a three year duration and 44 of 46 acute general hospitals are participating, as well as 3 specialty facilities. Ms. Epke commented that there has already been an improvement in central line associated blood stream infections (CLABSI). The Council will continue to be updated on the initiative at future quarterly meetings.

Dr. Davis then updated the group on the Blood Wastage Reduction Collaborative. The Collaborative has and saved a total of 1,255 combined units (platelets and plasma) for a savings of $494,191. Increased availability of a scarce resource is a program benefit that is unquantifiable. The Collaborative has set new goals for the 2011 calendar year: reduce the effective wastage rate of platelets by 7% (equates to 240 units) and of plasma by 10% (equates to 453 units). The combined impact of the Collaborative is estimated to be $600,000. The Inventory Visibility System, on which short-dated products are listed for other hospitals' use is in 30 facilities, including those in the DC Metropolitan area. This initiative has already received attention from the National Red Cross, who plans to take the initiative nationwide. The Collaborative hopes to publish results in the near future.

Finally Dr. Davis shared the workgroup's plans for a solicitation for future initiatives from various organizations and individuals, including professional groups, trade associations, advocacy groups and health insurers. Proposed projects should focus on improvement in healthcare quality, and should have hearty evidence-base that the practice is effective and safe. Generally projects will be applicable to the inpatient hospital setting, have a substantial impact in terms of quality improvement, possibly offer cost-savings in the short or long-term, and have some ease of implementation. Ease of implementation should be quantified in terms of cost of implementation, intensity of the human resources required, and time. The Workgroup will present recommendations for future initiatives at the June 10 Council meeting.

Prevention and Wellness: Future Initiatives - Frances Phillips, Deputy Secretary, Public Health Services, Madeleine Shea, Director, Office of Population Health Improvement and Audrey Regan, Director, Office of Chronic Disease Prevention, DHMH

Maddy Shea began the presentation (available on the MHQCC website) providing background on the new DHMH Office for Population Health Improvement, which is charged to develop goals, objectives, strategies and resources to improve health in Maryland. The HCRCC recommended the creation of a State Health Improvement Plan (SHIP). The SHIP will focus state and local action on a small number of critical population health improvement factors that are (1) critical to making sure people live, work and play in health supporting environments and (2) critical to ensuring that our prevention and health care services are of the highest quality. Maddy requested Council members comment on the overall vision, specific objectives and ideas to bend the cost curve. Public comment will be sought in April, building to the release of a state plan in June of 2011. Regional meetings will occur in the summer to launch local

implementation planning by county health departments, community health centers, local hospitals and other partners. The SHIP will position DHMH for accreditation in late 2011-2012.

Dr. Regan then presented on broad public health initiatives for consideration as future initiatives, citing the CDC's "winnable battles:" food safety; healthcare-associated infections; HIV; motor vehicle injuries; nutrition, physical activity, and obesity; teen pregnancy; and tobacco. The workgroup will sort through various policy ideas, set up criteria, analyze suggestions for initiatives grounded in public health. The Council members commented on the scale of the SHIP project and the optimal number of projects the State should take on to be successful. The Council agreed in the value of their role to act as a filter these various initiatives.

Health Disparities: Future Initiatives – Secretary Sharfstein, DHMH

Secretary Sharfstein began the discussion commenting on the need to build off of the State's efforts on the SHIP and begin a dialogue around initiatives this Council could promote to address disparities. As referenced by the Lt. Governor, the HCRCC identified a need to look at specific disparities in the health care system. Specifically the HCRCC recommended that the State explore strategies, including financial, performance-based incentives, to reduce and eliminate health disparities, and make recommendations regarding the development and implementation of these strategies. The Lt. Governor emphasized the need to use tools that the State already had available to modify the payment system in a way that will address disparities in the healthcare system. Council members commented on various resources that could be considered and recommended recent Institute of Medicine reports. Secretary Sharfstein suggested that a potential role for the Council could be to sort through disparities data and identify targets for action and entities should be accountable for specific strategies. The Council agreed that staff should work on the charge and scope of a potential Disparities Workgroup and report back at the June Council meeting.

The meeting adjourned at 11:45.